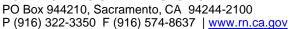


## **BOARD OF REGISTERED NURSING**





## ONLINE CLINICAL NURSE SPECIALIST APPLICANT IDENTIFICATION FORM

You <u>must</u> complete and submit this form via your online BreEZe account, or by mailing to: Board of Registered Nursing, ATTN: Advanced Practice Unit, P.O. Box 944210, Sacramento, CA 94244-2100.

Print Full Name:  (Last)  U.S. Social Security	(First)		(Middle)	
Number or Individual Tax Identification Number:	E-Mail:			
Address:		Date o Birth:	of	
Name of Clinical Nurse Program:				
City, State and Country of Clinical Nurse Specialist Program:				
HAVE YOU COMPLETED AND/OR ENCLOSED THE FOLLOWING ITEMS (check all that apply):				
Have you attached a recent 2" x 2" passport type phot	ograph?		☐ YES	□ №
If applicable, if you are relocating to California as a result of your spouse's/partner's active duty military service, is the supplemental information enclosed?			☐ YES	□ NO
If applicable, is supplemental information regarding report against licenses enclosed?	orting prior convictions or	discipline	☐ YES	□NO
I certify under penalty of perjury under the laws of the State of California, that all information provided in connection with this online application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.		Tape Your 2" x 2"  Passport Type		
		Photograph Here		
Signature of Applicant:				
Date:	Ĺ			